

Recommendations and Resources for the Control of Influenza 2012 - 2013

Everyone aged 6 months and older should receive flu vaccine every year.
Begin offering flu vaccine as soon as it is available.

What's new for the 2012-2013 Flu Season?

- New!* • **New dosing recommendations for children 6 months through 8 years of age.** See Figure 1 on page 3.
- New!* • **2012-2013 influenza vaccine**
 - A/California/7/2009 (H1N1)pdm09 (same as in the 2009 monovalent, and the 2010-2011 and 2011-2012 seasonal vaccines)
 - A/Victoria/361/2011 (H3N2) (replaces A/Perth/16/2009)
 - B/Wisconsin/1/2010, Yamagata lineage (replaces previous Victoria lineage B/Brisbane/60/2008)
- New!* • **H3N2v.** Over the past several months, CDC has confirmed human infection with a novel strain of influenza A H3N2 virus (referred to as influenza A(H3N2)v for övariantö) in a number of people. Formerly called swine-origin triple reassortant influenza A(H3N2), it is an influenza virus that contains genes from human, avian, and swine origins. To date, investigations of these cases revealed human infections with these viruses following contact with swine, particularly during agricultural fairs, as well as limited human-to-human transmission.

To date H3N2v has appeared to be similar to seasonal flu in terms of duration (3-5 days) and severity of illness; risk groups; infectious period (7 days from onset); and clinical management. Providers should consider prompt presumptive antiviral treatment of suspect cases. However, to date human-to-human transmission of H3N2v has been limited. No cases of H3N2v have been reported in Massachusetts as of August 28, 2012.

For more information, see the [MDPH Clinical Advisory Regarding Influenza A \(H3N2v\)](#), and visit the CDC website [Interim Information for Clinicians about Human Infections with H3N2v Virus](#).
- Manufacturers began shipping 2012-2013 influenza vaccine in July 2012. It is expected that there will be plenty of flu vaccine to meet the demand this flu season.

Influenza Vaccination Rates in Massachusetts by Age, 2010-2011 Influenza Season, Aug 2010– May 2011

Age Group	Percent Vaccinated
Everyone \geq 6 mos	52%
Children 6 mos – 17 years	65%
• Children 6 mos ó 4 years	83%
• Children 5 ó 12 years	59%
• Children 13 ó 17 years	53%
Adults \geq 18 yrs	49%
• Adults 18 ó 64 yrs, High Risk	45%
• Adults 18 ó 49 yrs	38%
• Adults 50 ó 64 yrs	54%
• Adults \geq 65 yrs	73%

Your recommendation and offer of vaccine are the most important determinates of whether or not your patient gets vaccinated.

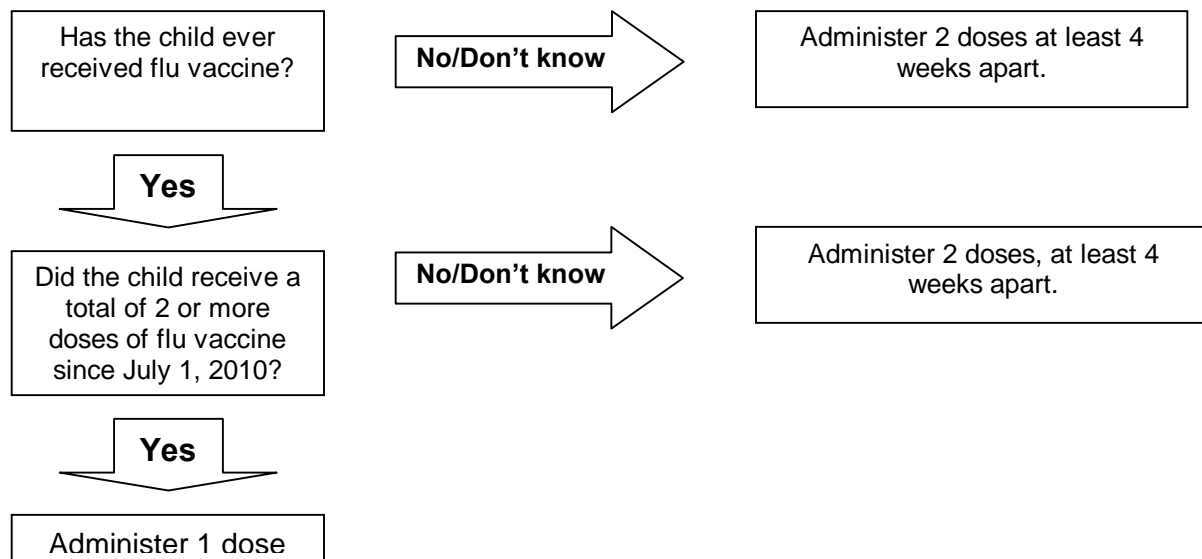
An article entitled [Influenza Vaccination Coverage among Pregnant Women in the United States for the 2010-11 Influenza Season](#), (MMWR Aug 17, 2011) estimated influenza vaccination coverage among pregnant women for the 2010-11 season. The survey found that **women whose providers offered them a flu shot were 5 times more likely to get vaccinated** than women who didn't receive a provider offer. However, 4 out of 10 women in this survey did not receive a provider offer, although they had visited a provider at least once. Women with a negative attitude toward vaccination who had received a provider offer of vaccination were more likely to be vaccinated than women who had a positive attitude without a provider offer. The study underscores the importance of providers not only strongly recommending vaccination, but **offering vaccine on site** to ensure that their patients are protected.

Influenza Vaccine for Children

Vaccine dose considerations for children 6 months through 8 years of age: Children 6 months through 8 years of age require 2 doses of influenza vaccine (administered at least 4 weeks apart) during their first season of vaccination to optimize immune response. Because of the antigenic novelty of the 2009(H1N1) pandemic virus, which is anticipated to continue circulating during 2012-2013, exposure history to this vaccine virus antigen must also be considered. Please use the algorithm below to determine which children 8 years of age and younger need 2 doses of flu vaccine this season.

Figure 1: Influenza vaccine dosing algorithm for children 6 months through 8 years of age 2012-2013

In situations where there is limited information about a child's influenza vaccination history, use the algorithm below to determine whether a child 6 months through 8 years of age needs one or 2 doses of flu vaccine this season.



For simplicity, the algorithm above takes into consideration only doses of seasonal influenza vaccine received since July 1, 2010. As an alternative approach in settings where vaccination history from prior to July 1, 2010 is available, if a child 6 months through 8 years of age is known to have received at least 2 seasonal flu vaccines during any prior season, and at least 1 dose of a 2009(H1N1)-containing vaccine--i.e., either 2010-2011 or 2011-2012 seasonal vaccine or the monovalent 2009(H1N1) vaccine--then the child needs only 1 dose for 2012-2013.

Using this approach, children 6 months through 8 years of age need only 1 dose of vaccine in 2012-2013 if they have received any of the following:

- 2 or more doses of seasonal influenza vaccine since July 1, 2010; or
- 2 or more doses of seasonal influenza vaccine before July 1, 2010 and 1 or more doses of monovalent 2009 H1N1 vaccine; or
- 1 or more doses of seasonal influenza vaccine before July 1, 2010 and 1 or more doses of seasonal influenza vaccine since July 1, 2010.

Children 6 months through 8 years of age who do not meet one of these conditions require 2 doses in 2012-2013.

Do not use Afluria in children aged 6 months through 8 years. In April 2010, Australia suspended 2010-2011 seasonal trivalent influenza vaccinations for all children <5 years after reports of febrile seizures following vaccination. Administration of CSL's 2010 Southern Hemisphere influenza vaccine Fluvax has been associated with increased postmarketing reports of fever and febrile seizures in children predominantly below the age of 5 years as compared to previous years.

Use other age-appropriate licensed flu vaccine formulations to prevent flu in these children. If no other age-appropriate flu vaccine is available for a child aged 5 through 8 years who has a medical condition that increases their risk for complications, Afluria may be given. Discuss the benefits and risks of flu vaccination with the parents or caregivers before administering Afluria.

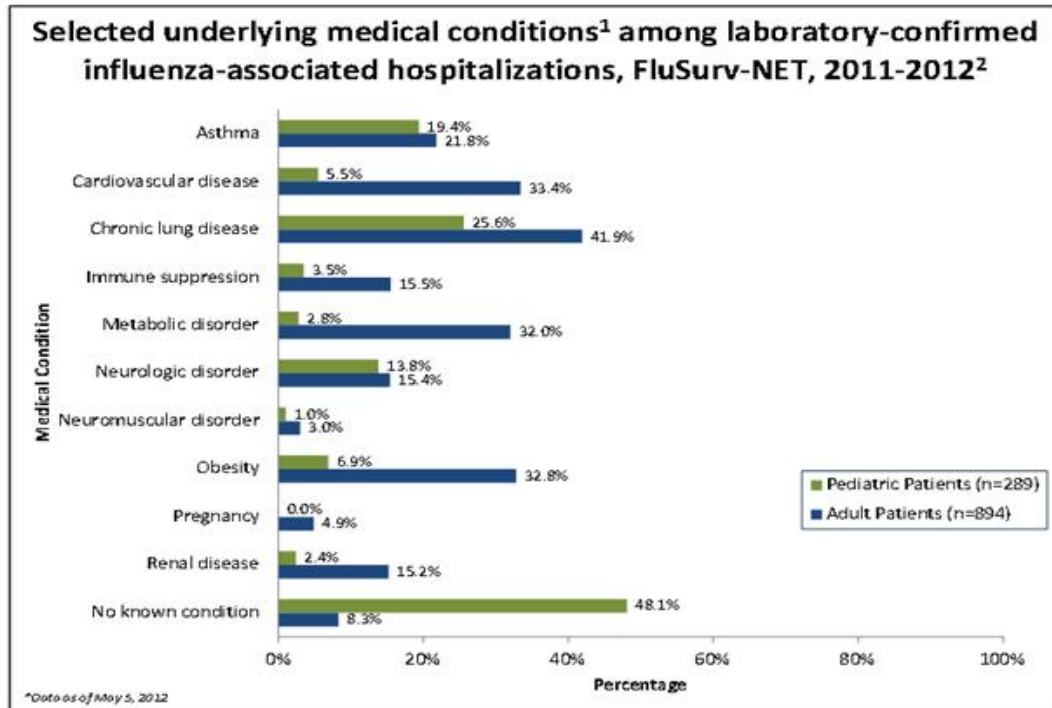
Simultaneous administration of TIV and PCV13 and risk of febrile seizures. The inactivated influenza vaccine VIS states that, “young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time appear to be at increased risk for seizures caused by fever.” ACIP chose to include this statement on the VIS to inform parents of this potential risk. After evaluating the data on febrile seizures from the 2010-2011 flu season and taking into consideration benefits and risks of vaccination, no policy change was recommended for use of TIV or PCV13 for the 2011-2012 season. Findings from surveillance for febrile seizures in young children following influenza vaccine for the 2011-2012 flu season (same formulation as 2010-2011) were consistent with the 2010-2011 flu season (CDC unpublished data). No changes in the use of TIV or PCV13 are recommended for the 2012-2013 influenza season. **ACIP does not recommend administering them at separate visits or deviating from the recommended vaccine schedule in any way.**

Screen for possible reactive airway disease before using LAIV for children aged 2 - 4 years. Do not use LAIV in children with asthma or a recent wheezing episode. If yes to either of the 2 questions below, use TIV.

- History of asthma or recurrent wheezing within the past 12 months in the medical record
- Ask parent: “In the past 12 months, has a health care provider told you that your child has wheezing or asthma?”

General Recommendations for the 2012-2013 Influenza Season

Everyone 6 months of age and older should receive flu vaccine every year. A list of groups at increased risk for influenza-related complications can be found at www.cdc.gov/flu/professionals/acip/specificpopulations.htm.



¹Asthma includes a diagnosis of asthma or reactive airway disease; Cardiovascular diseases include conditions such as coronary heart disease, cardiac valve disorders, congestive heart failure, pulmonary hypertension, and aortic stenosis; Chronic lung diseases include conditions such as asthma, bronchiolitis obliterans, chronic aspiration pneumonia, and interstitial lung disease; Immune suppression includes conditions such as immunoglobulin deficiency, leukemia, lymphoma, HIV/AIDS, and individuals taking immunosuppressive medications; Metabolic disorders include conditions such as diabetes mellitus, thyroid dysfunction, adrenal insufficiency, and liver disease; Neurologic diseases include conditions such as seizure disorders, cerebral palsy, and cognitive dysfunction; Neuromuscular diseases include conditions such as multiple sclerosis and muscular dystrophy; Obesity was assigned if indicated in patient's medical chart or if body mass index (BMI) >30 kg/m²; Renal diseases include conditions such as acute or chronic renal failure, nephrotic syndrome, glomerulonephritis, and impaired creatinine clearance.

²Only includes cases for which data collection has been completed through the medical chart review stage.

Massachusetts regulations require health care facilities to offer flu vaccine to employees. Regulations (105 CMR 130.325; 105 CMR 140.150; and 105 CMR 150.002(D)(8)) require licensed clinics, dialysis centers, hospitals, and long-term care facilities to provide information about the risks and benefits of flu vaccine and flu vaccine at no cost to all employees. Please see the DPH Division of Health Care Quality circular letter 09-12-526 at www.mass.gov/dph/dhcq. For questions or reporting employee vaccination rates in your facility, contact HCQ at 800-462-5544

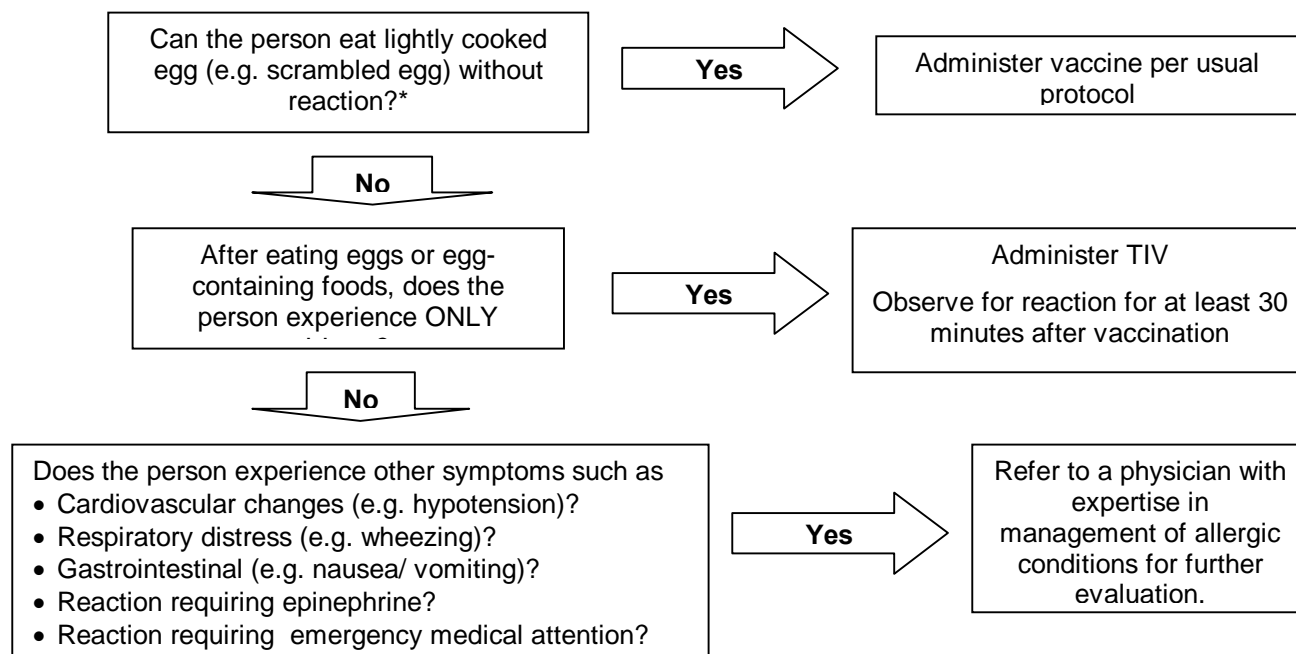
Use trivalent inactivated influenza vaccine (TIV) for people at higher risk of complications because of underlying medical conditions, children aged 6 - 23 months, and people aged ≥ 50 years. Use either TIV or attenuated influenza vaccine (LAIV) for healthy, non-pregnant people aged 2 through 49 years, including health care personnel and other contacts of high-risk groups.

Egg Allergies: ACIP recommends the following approach for administration of influenza vaccine to people with a history of egg allergy.

1. Individuals who have experienced only hives following exposure to egg should receive influenza vaccine with the following additional measures (Figure 2):
 - a) Use TIV rather than LAIV;
 - b) Vaccine should be administered by a healthcare provider who is familiar with the potential manifestations of egg allergy; and
 - c) Observe vaccine recipients ≥ 30 minutes for signs of a reaction following administration of each vaccine dose.Other measures, such as dividing and administering the vaccine by a two-step approach and skin testing with vaccine, are not necessary.
2. Persons who report having had reactions to egg involving such symptoms as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or other emergency medical intervention, particularly those that occurred immediately or within a short time following egg exposure (minutes to hours) are more likely to have a serious systemic or anaphylactic reaction upon re-exposure to egg proteins. Prior to receipt of vaccine, refer such individuals to a physician with expertise in the management of allergic conditions for further risk assessment.
3. Administer all vaccines in settings in which personnel and equipment for rapid recognition and treatment of anaphylaxis are available. The ACIP recommends that all vaccination providers should be familiar with the office emergency plan.
4. Some individuals who report allergy to egg may not be egg-allergic. Those who are able to eat lightly cooked egg (e.g., scrambled egg) without reaction are unlikely to be allergic. Egg allergic persons may tolerate egg in baked products (e.g. bread, cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy. Confirm egg allergy by a consistent medical history of adverse reactions to eggs and egg-containing foods, plus a skin and/or blood testing for IgE antibodies to egg proteins.
5. A prior severe allergic reaction to influenza vaccine, regardless of the component suspected to be responsible for the reaction, is a contraindication to future receipt of the vaccine.

These recommendations are summarized in the algorithm below.

Figure 2. Recommendations Regarding Influenza Vaccination for People Who Report Allergy to Eggs, 2012-2013 Flu Season.



*Persons with egg allergy might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy.

Timing of flu vaccination:

- Begin vaccinating as soon as vaccine is available. Continue vaccinating as long as flu is circulating in the community. In New England, this is usually through April and May.
- End of season vaccination may particularly benefit the following people:
 - People likely to be traveling to the Southern Hemisphere, where flu may be circulating, and
 - Children younger than 9 years of age being vaccinated for the first time who still have not received their second recommend dose of vaccine.

Information for Travelers: The Southern Hemisphere experiences its flu season from April through September, and flu activity can occur year-round in the tropics. People traveling to parts of the world where flu activity is ongoing, and who have not received flu vaccine for the current season, should get vaccinated. This is particularly important for people at risk for flu-related complications. This also applies to people who are traveling in the temperate regions of the Northern Hemisphere as part of tourist groups (e.g., on cruise ships) that may include people from other parts of the world where flu activity is ongoing. For more information, go to: www.cdc.gov/flu/travelers/travelersfacts.htm

Medicare Part B Reimbursement for Administration of Flu and Pneumococcal Vaccines as of 4/2012 is \$26.86/dose in metro-Boston and \$25.29/dose in the rest of the state. This is in addition to reimbursement for the cost of the vaccine itself. For more information, see www.cms.hhs.gov/AdultImmunizations/.

Use annual flu vaccination to assess patients for the need for other vaccines,

including Tdap and pneumococcal vaccine.

Where to purchase vaccine: You can order vaccine from a pharmaceutical distributor or directly from the manufacturers below.

Approved Influenza Vaccines for Different Age Groups¹

Manufacturer	Trade Name	Dose/ Presentation	Thimerosal (mcg Hg/0.5 mL dose)	Ovalbumin Content (mcg/ 0.5 mL dose)	Age Group
Sanofi Pasteur 800-822-2463 www.vaccineshoppe.com/	Fluzone® Inactivated	0.25 mL prefilled syringe	0	0.05/0.25 mL ⁴	6-35 mos
		0.5 mL prefilled syringe	0	0.1 ⁴	≥ 36 mos
		0.5 mL single dose vial	0	0.1 ⁴	≥ 36 mos
		5.0 mL multidose vial	25	0.1 ⁴	≥ 6 mos
	Fluzone High-Dose® ²	0.5 mL prefilled syringe	0	0.1 ⁴	≥ 65 yrs
	Fluzone Intradermal® ³	0.1 mL prefilled microinjection syringe	0	0.02/dose ²	18-64 yrs
Novartis 800-244-7668 www.novartisvaccinesdirect.com/index	Agriflu®	0.5 mL prefilled syringe	0	≤ 0.4	≥ 18 yrs
	Fluvirin® Inactivated	0.5 mL prefilled syringe	≤ 1	≤ 1	≥ 4 yrs
		5.0 mL multidose vial	25	≤ 1	≥ 4 yrs
GlaxoSmithKline 866-475-8222 www.gskvaccinesdirect.com/gsk/en/US/adirect/gsk	Fluarix®, Inactivated	0.5 mL prefilled syringe	0	≤ 0.05	≥ 3 yrs
	FluLaval® , Inactivated	5.0 mL multidose vial	25	≤ 1	≥ 18 yrs
CSL Biotherapies 888-435-8633	Afluria® ⁵ , Inactivated	0.5 mL prefilled syringe	0	≤ 1	≥ 9 yrs ¹
		5.0 mL multidose vial	24.5	≤ 1	≥ 9 yrs ¹
MedImmune 877-358-6478	FluMist® Live attenuated intranasal	0.2 mL sprayer, divided dose	0	See Footnote 6 below	2-49 yrs

¹ There is no preferential recommendation among any of the formulations of TIV or LAIV, but please note the recommended age groups and possible contraindications for each vaccine.

² A 0.5-mL dose contains 60 µg of each vaccine antigen (180 µg total).

³ A 0.1-mL dose contains 9 µg of each vaccine antigen (27 µg total).

⁴ Personal communication from Sanofi Pasteur 8/21/2012.

⁵ Based upon available information to date, the ACIP recommends the following:

- Do not use Afluria in children aged 6 months through 8 years.
- Use other age-appropriate, licensed seasonal influenza vaccine formulations to prevent influenza in children aged 6 months through 8 years.
- If no other age-appropriate, licensed seasonal influenza vaccine is available for a child aged 5 years through 8 years who has a medical condition that increases their risk for influenza complications, Afluria may be given. Discuss the benefits and risks of influenza vaccination with the parents or caregivers before administering Afluria.

⁶ Insufficient data available for use of LAIV in egg-allergic patients.

Surveillance, Testing and Reporting

Surveillance: Conduct surveillance for respiratory illness and use influenza testing to identify outbreaks so infection control measures can be promptly initiated in all settings, including inpatient and outpatient settings. Call DPH at 617-983-6800 for guidance and assistance with surveillance and control measures.

Influenza testing: Diagnostic testing for influenza can aid clinical judgment and guide treatment decisions and control measures.

- Diagnostic tests for influenza performed at the Hinton State Laboratory Institute (SLI) include viral culture and influenza RNA detection by polymerase chain reaction (PCR).
- Point of care rapid antigen testing capable of detecting influenza A and B virus infections is not routinely performed at the SLI but is widely available at hospitals, private providers, and other healthcare settings. Rapid influenza diagnostic tests have limited sensitivity and false negative results are common. False positive tests can also occur and are more likely when flu is rare in the community. For more information and guidance on use of rapid influenza diagnostic tests, visit CDC's influenza website at www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm.
 - In addition, rapid antigen testing and commercially-available RT-PCR tests may not detect novel or variant strains of influenza and can not differentiate between seasonal and novel or variant influenza. Therefore, respiratory specimens should be collected from any patient suspected of having infection with H3N2 or any novel or variant strain of influenza and sent for reverse-transcription polymerase chain reaction (RT-PCR) testing using CDC diagnostic panels at the **Hinton State Laboratory Institute**.
- When laboratory confirmation is desired, testing by RT-PCR and/or viral culture is recommended. PCR and viral culture testing also provide essential information on circulating influenza subtypes and strains.
- For information on influenza specimen collection and transportation, or to speak with an immunization epidemiologist, call MDPH at 617-983-6800. For specimen collection kits, call the kit room at the SLI at 617-983-6640.
- The MDPH Instructions for specimen submission can be found at: www.mass.gov/eohhs/docs/dph/laboratory-sciences/flu-virus-collection.pdf
- The HSLI [Specimen Submission Form](#) can be found at www.mass.gov/eohhs/docs/dph/laboratory-sciences/flu-specimen-submission-form.pdf

Reporting: In accordance with 105 CMR 300.000 (Reportable Diseases, Surveillance and Isolation and Quarantine Requirements), all positive laboratory findings indicative of influenza virus infection are reportable directly to MDPH.

Immediately report the following influenza-related cases by phone to the Division of Epidemiology and Immunization 617-983-6800 and to your local board of health. This applies to all strains of influenza:

- ☎ Deaths related to influenza in children under 18 and in pregnant women
- ☎ ICU admissions of pregnant women with influenza
- ☎ Confirmed cases of influenza with encephalopathy, myocarditis, or pericarditis
- ☎ Case(s) or clusters of ILI in long-term care facilities or in high risk settings
- ☎ Cases of antiviral treatment or prophylaxis failure
- ☎ Suspect novel or variant influenza, e.g., travel-associated, animal-associated, avian influenza, H3N2v
- ☎ Clusters of ILI or ARI¹ in daycare and elementary schools

¹ **Acute respiratory illness:** recent onset of at least two of the following:

New!

- ☎ Patients with unusual or severe presentations of ILI or ARI, especially young children
- ☎ ILI in employees of commercial swine farms

Providers in the city of Boston should report these cases directly to the Boston Public Health Commission.

Outbreaks in hospitals, long term care facilities and other entities licensed by the Division of Healthcare Quality (DHCQ) should also be reported to DHCQ at 800-462-5540 x8150.

For less severe influenza-related cases and situations, DPH has created a one-page form that providers can use to report individuals with suspect or confirmed influenza who are at high risk for complications (e.g., pregnant women, hospitalized cases). Please call (617) 983-6801 to obtain a copy of the *Influenza and ILI Significant Case Reporting Form*; reports can then be submitted via fax to DPH at (617) 983-6220. The goal of reporting such high risk cases is to track the progression of influenza within the state on a real time basis.

For specific information about reporting, see the MDPH Reportable Diseases, Surveillance and Isolation and Quarantine Requirements website at www.mass.gov/eohhs/docs/dph/cdc/reporting/rdq-reg-summary.rtf.

Please note that additional jurisdiction-specific reporting requirements may also apply. Healthcare providers and laboratories within the city of Boston must also report all cases of influenza and all laboratory tests positive for influenza directly to the Boston Public Health Commission (see www.bphc.org/ or contact BPHC at 617-534-5611 for additional information).

Additional information on the prevention and control of influenza can be found in the influenza chapter of the MDPH Guide to Surveillance, Reporting and Control, at www.mass.gov/eohhs/docs/dph/disease-reporting/guide/influenza.rtf.

Infection Control

To prevent the transmission of **all** respiratory infections, including influenza, in health care settings, implement the following infection control measures at the first point of contact with a potentially infected person. These should be incorporated into infection control practices as one component of standard precautions. Tools to help promote and implement these recommendations are available at www.cdc.gov/flu/professionals/infectioncontrol.

To date human-to-human transmission of H3N2v has been very limited. At this time, the infectious period of the variant flu strain is unknown, but it is assumed to be similar to the infectious period of seasonal influenza. Therefore, infected persons should be assumed to be contagious up to 7 days from illness onset. Younger persons and immunocompromised persons may be contagious longer. Control measures, treatment, and prophylaxis for this variant are the same as for seasonal influenza and include prompt presumptive use of antiviral agents for treatment and prophylaxis if infection with H3N2v is suspected.

Active surveillance and testing for new illness and cases: Educate staff about the signs and symptoms of influenza-like illness.

Respiratory hygiene/cough etiquette: Post visual alerts (in appropriate languages) at the entrance to outpatient facilities (e.g., emergency departments, physician offices, outpatient clinics) instructing patients and persons who accompany them (e.g., family, friends) to inform health care personnel of symptoms of a respiratory infection when they first register for care and to practice respiratory hygiene/cough etiquette. Posters, brochures and fact sheets promoting **cough etiquette** and **handwashing** in multiple languages are available from DPH by calling 617-983-6800 or they can be downloaded from www.mass.gov/handwashing.

Rhinorrhea or nasal congestion Sore throat Cough Fever or feverishness

Use **standard precautions** (www.cdc.gov/hicpac/2007IP/2007ip_part3.html#a) with all patients. Use droplet precautions (www.cdc.gov/hicpac/2007IP/2007ip_part3.html#b) when caring for patients with suspected or confirmed influenza.

Assess the influenza and pneumococcal vaccination status of all patients and the flu vaccination status of all staff. Vaccinate all susceptible patients and staff.

Antiviral drugs are an adjunct to, not a substitute for, vaccination for preventing and controlling influenza. The neuraminidase inhibitors oseltamivir (Tamiflu®) and zanamivir (Relenza®) are currently recommended for use against circulating influenza viruses. The adamantanes (amantadine and rimantadine) are **not** recommended because of high levels of resistance to these drugs among recently circulating influenza A (H3) and 2009 H1N1 influenza viruses.

Clinical judgment is an important factor in treatment decisions for patients presenting with influenza-like illness. Prompt empiric antiviral treatment with influenza antiviral medications is recommended while results of definitive diagnostic tests are pending, or if diagnostic testing is not possible, for patients with clinically suspected influenza illness who have:

- Illness requiring hospitalization,
- Progressive, severe, or complicated illness, regardless of previous health status, and/or
- Patients at increased risk for severe disease (see page 3).

Antiviral treatment, when clinically indicated, should **not be delayed pending definitive laboratory confirmation of influenza**. Influenza antiviral medications are most effective when initiated within the first 2 days of illness, but these medications may also provide benefits for severely ill patients when initiated even after 2 days.

Point of care rapid tests capable of detecting influenza A and B virus infections are available, but health care providers and public health personnel should be aware that rapid influenza diagnostic tests have limited sensitivity and false negative results are common. Thus, negative results from rapid influenza diagnostic test should not be used to guide decisions regarding treating patients with influenza antiviral medications. In addition, false positive tests can occur and are more likely when influenza is rare in the community. When laboratory confirmation is desired, use RT-PCR and/or viral culture.

Guidance on use of antivirals may change depending upon resistance data. Consult CDC's latest recommendations on antiviral use at www.cdc.gov/flu/professionals/antivirals/.

Clinicians should be alert to changes in antiviral recommendations that might occur as additional antiviral resistance data becomes available during the 2012-2013 season.

Additional information

CDC. Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP, 2012. MMWR August 17, 2012;613-618. www.cdc.gov/mmwr/pdf/wk/mm6132.pdf

CDC. Prevention and control of influenza with vaccines: recommendation of the ACIP, 2010. MMWR Early Release 2010;59 July 29, 2010:1-62. www.cdc.gov/mmwr/pdf/rr/rr59e0729.pdf

CDC. Influenza vaccination of health-care personnel: recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) 2006;55(No. RR-2). www.cdc.gov/mmwr/preview/mmwrhtml/rr5502a1.htm.

Vaccine Information Statements (VISs) for all vaccines in many languages: www.immunize.org/vis.

Standing orders for LAIV, TIV, pneumococcal vaccine, Tdap and other vaccines are available at www.mass.gov/dph.

Visit the MDPH web site (www.mass.gov/flu). Hard copies and technical consultation are available by calling MDPH at 617-983-6800 or 888-658-2850.